AIR AMBULANCE SERVICES

ELIGIBLE PROVIDERS

In order to receive payment, all eligible servicing and billing provider's National Provider Identifiers (NPI) must be enrolled with South Dakota Medicaid. Servicing providers acting as a locum tenens provider must enroll in South Dakota Medicaid and be listed on the claim form. Please refer to the provider enrollment chart for additional details on enrollment eligibility and supporting documentation requirements.

South Dakota Medicaid has a streamlined enrollment process for eligible ordering, referring, and attending providers that may require no action on the part of the provider as submission of claims constitutes agreement to the South Dakota Medicaid Provider Agreement.

South Dakota air ambulances must be licensed and equipped according to ARSD Ch. 44:05:05.
Out-of-state providers must be licensed and enrolled with their home state's Medicaid agency.

ELIGIBLE RECIPIENTS

Providers are responsible for checking a recipient's Medicaid ID card and verifying eligibility before providing services. Eligibility can be verified using South Dakota Medicaid's online portal.
The following recipients are eligible for medically necessary services covered in accordance with the limitation described in this chapter and in the table below:

Coverage Type	Coverage Limitations
Medicaid/CHIP Full Coverage	Medically necessary services covered in accordance with the limitations described in this chapter.
Qualified Medicare Beneficiary – Coverage Limited (73)	Coverage restricted to co-payments and deductibles for Medicare Part A and Part B covered services.
Unborn Children Prenatal Care Program (79)	Coverage restricted to pregnancy related services only including medical issues that can harm the life of the mother or baby.

Refer to the Recipient Eligibility manual for additional information regarding eligibility including information regarding limited coverage aid categories.

COVERED SERVICES AND LIMITS

General Coverage Principles

Providers should refer to the General Coverage Principles manual for basic coverage requirements all services must meet. These coverage requirements include:

- The provider must be properly enrolled;
- Services must be medically necessary; and
- The recipient must be eligible.

The manual also includes non-discrimination requirements providers must abide by.

Air Ambulance Coverage

Air ambulance services by means of a helicopter or fixed wing aircraft are limited to transporting a recipient to the nearest appropriate facility that is equipped or trained to provide the necessary service. Air ambulance services must meet the following criteria:

- The transportation is medically necessary because of time, distance, emergency, or other factors or when transportation by any other means is contraindicated;
- The recipient's medical condition required immediate and rapid ambulance transportation that could not have been provided via ground ambulance;
- The transportation must be the result of a physician or other licensed practitioner's written orders requiring the specific level of air transportation for medical purposes;
- The air ambulance must be licensed and equipped according to ARSD Ch. 44:05:05.

Medical Necessity

Medical necessity is only established when the recipient's condition is such that the time needed to transport a recipient by ground, or the instability of transportation by ground, poses a threat to the recipient's survival or seriously endangers the recipient's health.

The following are examples of instances when air ambulance may be justified. The list is not inclusive of all situations that justify air transportation and is not intended to justify air transportation in all circumstances.

- Intracranial bleeding - requiring neurosurgical intervention;
- Cardiogenic shock;
- Burns requiring treatment in a burn center;
- Conditions requiring treatment in a Hyperbaric Oxygen Unit;
- Multiple severe injuries; or
- Life-threatening trauma.

Time Needed for Ground Transport

There are very limited emergency cases where ground transportation is available but the time required to transport the patient by ground as opposed to air endangers the recipient's life or health. As a general guideline, when it would take a ground ambulance 30-60 minutes or more to transport a recipient whose medical condition at the time of pick-up required immediate and rapid transport due to

the nature and/or severity of the recipient's illness/injury air transportation is considered necessary.

Covered Services

The following services are eligible for payment when provided by a participating ambulance provider that meets the above-criteria:

- Base fee for fixed wing emergency air ambulance, including one attendant;
- Base fee helicopter emergency air ambulance, including one attendant;
- Services of additional attendants if medically necessary;
- Transportation of an additional South Dakota Medicaid recipient when billed with the TK modifier; and
- Loaded mileage. Mileage may not be billed for more than one recipient per trip.

Hospital to Hospital Transport

Air ambulance transport is covered for transfer of a recipient from one hospital to another if the medical necessity criteria are met, that is, transportation by ground ambulance would endanger the recipient's health and the transferring hospital does not have adequate facilities to provide the medical services needed by the patient. Examples of such specialized medical services that are generally not available at all type of facilities may include but are not limited to: burn care, cardiac care, trauma care, and critical care.

A patient transported from one hospital to another hospital is covered only if the hospital to which the patient is transferred is the nearest one with appropriate facilities. Coverage is not available for transport from a hospital capable of treating the patient because the patient and/or the patient's family prefer a specific hospital or physician.

Transport to or from Airport

Transportation of a recipient from the airport to the hospital or from the hospital to the airport must be billed by the ground ambulance provider and may not be included in the air ambulance charges.

Transport Cancelled due to Weather or Other Circumstances

The table below shows the Medicaid coverage and reimbursement for air ambulance scenarios in which the flight is cancelled due to bad weather or other circumstance beyond the pilot's control.

Cancelled Flight Scenario	Medicaid Reimbursement
Any time before the recipient is loaded onboard (i.e., prior to or after take-off to point-of-pickup.)	Not covered.
Transport after the recipient is loaded onboard.	Air base fee, loaded mileage if applicable, additional attendant if applicable, and additional recipient if applicable.

Multiple Trips in a Single Day

If a recipient requires multiple trips via air ambulance within a 24-hour period, the 59 modifier must be billed on the claim along with other appropriate ambulance modifiers.

Multiple Recipient Transport
If two recipients are transported to the same destination simultaneously, services for the additional recipient must be billed with the TK modifier. The TK modifier reduces the base fee reimbursement for the second recipient by 50 percent. Loaded mileage is only billable for one recipient and must not be billed for the second recipient.

Recipient Death
Medicaid allows reimbursement for an air ambulance service when the air ambulance takes off to pick up a Medicaid recipient, but the recipient is pronounced dead before being loaded onto the ambulance for transport (either before or after the ambulance arrives on the scene). This is provided the air ambulance service would otherwise have been medically necessary.

In such a circumstance, the allowed amount is the appropriate air base rate, i.e., fixed wing or rotary wing. Mileage is not reimbursable. For the purpose of this policy, a pronouncement of death is effective only when made by an individual authorized under State law to make such pronouncements. The base fee is not billable or covered if the dispatcher received pronouncement of death and had a reasonable opportunity to notify. the pilot to abort the flight. In addition, the base fee is not covered or reimbursable if the aircraft has merely taxied but not taken off or, at a controlled airport, has been cleared to take off but not actually taken off.

The table below shows the Medicaid coverage and reimbursement for various air ambulance scenarios in which the recipient has died.

Time of Death Pronouncement	Medicaid Reimbursement
Prior to takeoff to point-of-pickup with notice to dispatcher and time to abort the flight.	Not covered. This includes situations in which the air ambulance has taxied to the runway, and/or has been cleared for takeoff, but has not actually taken off.
After takeoff to point-of-pickup, but before the recipient is loaded.	Air base rate with no mileage. Use the QL modifier when submitting the claim.
After the recipient is loaded onboard, but prior to or upon arrival at the receiving facility.	As if the recipient had not died.

Payment Limitations
If during a post payment review a determination is made that transportation via ground ambulance transport would have sufficed, payment for the air ambulance transport is based on the amount payable for ground ambulance transport.

If during a post payment review a determination is made that air transport was medically necessary (that is, ground transportation was contraindicated, and the beneficiary required air transport to a hospital), but the recipient could have been treated at a hospital nearer than the one to which they were transported, the air transport payment is limited to the rate for the distance from the point of pickup to that nearer hospital.

NON-COVERED SERVICES

General Non-Covered Services

Providers should refer to ARSD 67:16:01:08 or the General Coverage Principles manual for a general list of services that are not covered by South Dakota Medicaid.

Air Ambulance Non-Covered Services

The following services are non-covered:

- Charges for transporting a recipient from the airport to the hospital or from the hospital to the airport must be billed by the ground ambulance provider and may not be included in the air ambulance charge.
- A provider may not bill for services if a recipient was not transported.
- Services not specifically listed in the covered services section are considered non-covered.

DOCUMENTATION REQUIREMENTS

General Requirements

Providers must keep legible medical and financial records that fully justify and disclose the extent of services provided and billed to South Dakota Medicaid. These records must be retained for at least 6 years after the last date a claim was paid or denied. Please refer to the Documentation and Record Keeping manual for additional requirements.

Air Ambulance Documentation Requirements

A copy of the physician or other licensed practitioner's written order specifying the medical necessity and the level of air transportation medically required must be maintained in the provider's records and made available on request.

REIMBURSEMENT AND CLAIM INSTRUCTIONS

Timely Filing

South Dakota Medicaid must receive a provider's completed claim form within 6 months following the month the service was provided. Requests for reconsiderations will only be considered if they are received within the timely filing period or within 3 months of the date a claim was denied. The time limit may be waived or extended by South Dakota Medicaid in certain circumstances. Providers should refer to the General Claim Guidance manual for additional information.

Third-Party Liability

Medicaid recipients may have one or more additional source of coverage for health services. South Dakota Medicaid is generally the payer of last resort. Providers must pursue the availability of third-party payment sources and should use the Medicare Crossover or Third-Party Liability billing instructions when applicable. Providers should refer to the General Claim Guidance manual for additional information.

Reimbursement

The rate of payment for air ambulance service is the base fee, loaded mileage, and other medically necessary covered services. Payment is limited to the lesser of the provider's usual and customary charge or the fee contained on South Dakota Medicaid's Transportation Services fee schedule.

Claim Instructions

A claim for air ambulance must be submitted at the provider's usual and customary charge. A claim for air ambulance service may contain only air ambulance procedure codes found on the department's transportation fee schedule. A provider may only bill for loaded miles and air miles must be billed in nautical miles.

Transportation claims must list the address of the origin and destination. Providers should refer to the appropriate claim instructions for additional information.

Modifiers

If applicable, the following modifier codes must be included on a provider's claim:

- TK – Additional South Dakota Medicaid Recipient
- 59 – Distinct or separate services (multiple trips within a 24-hour period).
- Applicable descriptive modifiers are required to be included on the claim.

Modifier payment effects are described on the department's website

DEFINITIONS

1. "Air ambulance," an aircraft, fixed-wing or helicopter, that is designed or can be quickly modified to provide emergency transportation of wounded, injured, sick, invalid, or incapacitated human beings or expectant mothers to or from a place where medical care is provided and is licensed by the Department of Health under the provisions of chapter 44:05:05;

2. "Air mile," a unit of distance equal to one nautical mile;

3. "Ambulance provider," a company, firm, or individual licensed by the Department of Health under the provisions of article 44:05 to provide ambulance services or, if based out of state, a company, firm, or individual which provides ambulance services and is a participating Medicaid provider in the state where it is located;

4. "Loaded mileage," mileage driven or flown while a patient is being transported; and

5. "Trip," the transporting of a person from the person's home to a medical provider, between medical providers, or from a medical provider to the person's home.

REFERENCES

- Administrative Rule of South Dakota (ARSD)
- South Dakota Medicaid State Plan
- Code of Federal Regulation

QUICK ANSWERS

1. **Can an air ambulance bill for the transportation of the recipient from the airport to the hospital or from the hospital to the airport?**

   No, this must be billed by the ground ambulance per ARSD 67:16:25:08.

2. **Can an air ambulance bill for miles when the recipient is not being transported?**

   No, only loaded mileage is billable.

3. **What type of mileage unit of measurement should an air ambulance use to bill for loaded mileage?**

   Loaded mileage must be billed in nautical miles.